REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-24

Subject: Support for Mental Health Courts

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Referred to: Reference Committee B

INTRODUCTION

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 202 entitled, "Support for Mental Health Courts," was introduced by the Medical Student Section and called on the AMA to amend existing policy – Policy H-100.955 entitled, "Support for Drug Courts" – as follows:

> Our AMA: (1) supports the establishment and use of mental health ~~drug~~ courts, including drug courts and sobriety courts, as an effective method of intervention within a comprehensive system of community-based supports and services for individuals with mental illness involved in the justice system ~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health ~~drug~~ courts at the state and local level in the United States; and (3) encourages mental health ~~drug~~ courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

There was robust discussion of this resolution, including widespread support for increasing access to evidence-based care for individuals with a mental illness or substance use disorder (SUD) who were involved with the justice system. Multiple questions were raised, however, regarding terms of art that may be in use in legal settings compared to medical settings; the potential of unintended consequences; and the different uses of such courts. Ultimately, the HOD referred this resolution to the Board of Trustees for study. In response, this report provides background information; discusses the different courts; presents AMA policy; and makes recommendations.

BACKGROUND

There are more than 4,000 courts in the United States that provide some measure of alternative to incarceration when there is evidence of a mental illness, SUD, or other health condition impacting an individual and/or family.[1] There are at least 39 states with a diversion program that addresses substance use, and at least 24 that directly address mental health and illness needs.[2] A fact sheet from the Obama Administration noted that, "Since 1989, drug courts have been established or are being planned in all 50 States, the District of Columbia, the Northern Mariana Islands, Puerto Rico, Guam, and in nearly 90 Tribal locations."[3] The AMA has long been a supporter of these programs.[4]

These programs go by many names, including "treatment court," "adult drug court," "DWI court," "family treatment court," "juvenile treatment court," "tribal healing to wellness court," or "veterans treatment court." Other names used to describe programs that seek alternatives to incarceration are "opioid intervention court," "opiate treatment court," "heroin court," "treatment pathway

program," "overdose avoidance and recovery program," and "heroin overdose prevention and education initiative."[5] The U.S. Department of Justice (DOJ) broadly describes these programs as "pretrial diversion programs" to which the U.S. Attorney has discretion to "divert" if there are "substance abuse or mental health challenges."[6]

Given the many different types of programs that are designed to provide mental health or SUD services as an alternative to incarceration, for the purposes of this report, any program that addresses substance use or mental health in a justice-involved or justice-related setting or program will be denoted as a "diversion program." A recent issue brief from the National Conference of State Legislatures (NCSL)[7] further explains that "Pretrial diversion programs are post-arrest interventions that occur at some point prior to final entry of judgment. Programs can take place before charges are filed, before first appearance or before adjudication."

Public health and public justice and law enforcement officials generally agree on the considerable need to treat mental illness and SUDs. Data reported by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) show much greater prevalence of mental illness and SUDs in jails and prisons compared to the general population. It is estimated that:[8]

- 18 percent of the general population has a mental illness; 44 percent of those in jail and 37 percent of those in prison have a mental illness;
- 11 percent of 18–25-year-olds, and 6 percent of those over 25 years old have a SUD; and
- 63 percent of people in jail and 58 percent in prison have a SUD.

In terms of sheer numbers, "1.2 million individuals living with mental illness sit in jail and prison each year."[9] Making matters more challenging, more than 60 percent of individuals with a history of mental illness do not receive treatment while incarcerated, and more than 50 percent of individuals receiving medication for mental health conditions stop taking them upon being incarcerated.[10] The National Institutes on Drug Abuse says that estimates for SUD prevalence in jails and prisons have been as high as 65 percent.[11]

DISCUSSION

Are Diversion Programs an Effective Method of Intervention for Individuals with Mental Illness or Substance Use Disorder Involved with the Justice System?

The first issue to address is whether diversion programs are an effective method of intervention for individuals with a mental illness or SUD involved with the justice system. If so, what elements of a diversion program demonstrate efficacy? For the purposes of this report, at least two metrics for "efficacy" can be viewed as to whether individuals receive and continue to engage in treatment, as well as whether they become re-incarcerated. While it is beyond the scope of this report to evaluate the 4,000+ programs in existence in the United States, there are innumerable examples of programs reporting that individuals enrolled in diversion programs not only start and continue treatment but are also less likely to return to jail or prison or be re-arrested. Proponents of diversion programs cite multiple economic and other benefits, including that they can connect hundreds of thousands of individuals to medications for opioid use disorder (OUD).

A sample of meta-analyses also show general positivity, but identify challenges that come with evaluating such programs:

- A 2012 meta-analysis found that adult drug courts are effective "in reducing recidivism…[and] The evidence assessing DWI courts' effectiveness is very promising but more experimental evaluations are needed. Juvenile drug courts typically produce small reductions in recidivism."[12]
- A 2013 meta-review broadly found benefits of juvenile justice diversion programs.[13]
- A 2016 review of juvenile justice programs found, "There is no evidence that juvenile drug courts are more or less effective than traditional court processing in terms of reducing juveniles' recidivism and drug use, but there is also no evidence of harm. The quality of the body of evidence is very low, however, so we have little confidence in these null findings."[14]
- A 2016 guide from the National Drug Court Institute cited multiple studies showing that, "Use of all three [MOUD] medications is associated with significantly reduced use of unauthorized opioids among probationers, parolees, and other persons with opioid use disorders involved in the criminal justice system."[15]
- A 2017 review of mental health courts (MHC) found that, "Overall, a small effect of MHC participation on recidivism was noted, compared with traditional criminal processing. Findings suggest the need for research to identify additional sources of variability in the effectiveness of MHCs."[16]
- A 2019 systematic review of drug courts found that, "Treatment accessed via community-based diversion is effective at reducing drug use in Class A drug-using offenders. Evidence of a reduction in offending amongst this group as a result of diversion is uncertain. Poor methodological quality and data largely limited to US methamphetamine users limits available evidence."[17]
- A 2020 literature review of mental health courts found that, while research generally supports MHCs' positive effects to reduce recidivism, there are inconsistencies with overall study designs, data collection, lack of adequate controls and other methodological faults.[18]
- Another 2020 meta-analysis found that, "diversion programs for low-level drug offenders are likely to be cost-effective, generating savings in the criminal justice system while only moderately increasing healthcare costs. Such programs can reduce incarceration and its associated costs and avert overdose deaths and improve quality of life for PWID [people who inject drugs], PWUD [people who use drugs], and the broader population (through reduced HIV and HCV transmission)."[19]

Considering individual programs reporting broad benefits[20] and meta-analyses showing benefits as well as raising questions about how broad those benefits might be, it seems prudent to call for additional research as well as mechanisms to identify best practices. For example, some programs to treat OUD might prohibit use of medications for opioid use disorder (MOUD) or rely on non-evidence-based approaches. The Board of Trustees notes, however, that what works in one jurisdiction may not work in another—and given the evidence that points to the overall benefits and lack of harm, we believe that the AMA should continue to support these programs. To guide programs, we highlight that professional medical organizations have published multiple guidelines and treatment considerations for diversion programs and care for individuals involved with the justice system, including the American Society of Addiction Medicine,[21] American Psychiatric Association,[22] and Providers Clinical Support System.[23]

There are many potential elements of "a comprehensive system of community-based supports and services." This includes benefits provided by "wraparound services," such as community-based interagency cooperation, care coordination, child and/or family teams, unified plans of care, evidence-based systems of care, and other areas.[24] Additional guidance can be found in recent

SAMHSA grants for diversion programs in three jurisdictions.[25] These grants identify multiple types of services that may be useful in a diversion program, including motivational interviewing; crisis intervention training; psychiatric/psychosocial rehabilitation; dialectical behavior therapy; community-based treatment; case management; comprehensive psychiatric services, including psychotherapy and supportive counseling; substance use and detoxification treatment; housing and employment support, including skills training; screening, assessment, referral, and treatment to individuals at risk of entering the criminal justice system; and links between individuals and other community resources. While not all diversion programs will have all these elements, the Board of Trustees believes that the AMA should support development of diversion programs that include broad-based community support that include these types of resources.

Should Diversion Programs be Available to Both Nonviolent and Violent Offenders?

The second issue is whether diversion programs should be available to both nonviolent and violent offenders. It is first important to distinguish that *access to a diversion program* is related to—but different from than *access to evidence-based treatment* for a mental illness or SUD within the justice system. In 2022, the DOJ issued guidance making it clear that the Americans with Disabilities Act (ADA) protects individuals with an OUD to continue treatment for an OUD while incarcerated, including protecting continuity of care with MOUD.[26] The AMA has advocated in multiple legal, legislative, and other forums that individuals involved with the justice system have a medical—and constitutional right—to continue OUD while incarcerated. This advocacy is highlighted in seminal cases: *Smith v. Aroostook County*[27] and *Pesce v. Coppinger.*[28] By extension, an individual also likely has statutory and constitutional rights to MOUD—or other evidence-based care—in a diversion program, but as the DOJ points out, there may be nuances if "the individual is currently engaged in illegal drug use."[29] The National Institute on Drug Abuse (NIDA) explains that:

> The chronic nature of addiction means that for some people relapse, or a return to drug use after an attempt to stop, can be part of the process, but newer treatments are designed to help with relapse prevention. Relapse rates for drug use are similar to rates for other chronic medical illnesses. If people stop following their medical treatment plan, they are likely to relapse.[30]

The Board of Trustees believes that AMA support for individuals being able to stay in treatment even if they engaged in illegal drug use is a natural extension of existing AMA policy to not punish people because they have a SUD.

With respect to whether diversion programs should be available to non-violent and violent offenders, given the evidence showing benefits of these programs—even if limited in some cases—the AMA should continue to support access to evidence-based care, including MOUD, for non-violent offenders. Notably, no change in policy is needed to meet this result. Whether to support and advocate for diversion programs to be available to individuals charged or convicted of violent offenses, however, raises multiple issues.

The first issue is whether those charged or convicted of a violent offense are legally eligible for a diversion program. The U.S. Government Accountability Office (GAO) reports that, "adult drug courts funded by DOJ grants are prohibited by law from using grant funding to include individuals with prior or current violent offenses in their programs."[31] The GAO pointed out, however, that, "a few adult drug courts told us that they admit violent offenders, by ensuring that they do not use federal funding to serve these clients." The GAO, which interviewed representatives from 44 adult drug courts from a mix of rural, suburban, urban, and tribal adult drug courts, highlighted that some

violent offenders and those convicted of drug-related crimes would benefit from drug court services. State law also commonly excludes individuals charged or convicted of a violent offense—or having been convicted within a certain time period in the past.

The National Association of Drug Court Professionals counsels that, "Evidence does not support blanket disqualification from treatment court for persons with a history of violent crimes. Instead, persons charged with offenses involving violence, or who have a history of such offenses, should be evaluated on a case-by-case basis to determine if they can be safely supervised in treatment court."[32] The Board of Trustees agrees. Just as AMA policy does not discriminate against an individual's right to receive treatment based on external factors, the AMA should not discriminate against access to evidence-based care for SUD and mental illness based on carceral status or judicial supervision. As noted above, the provision of evidence-based care for mental illness and SUDs has strong constitutional protections. And as discussed below, current AMA policy strongly supports evidence-based care for individuals with a mental illness or SUD in jails and prisons.

Saying that the AMA should not oppose participation in a diversion program does not mean, however, that there should not be comprehensive considerations about which individuals would benefit most from participation in a diversion program. Such considerations, moreover, should include whether an individual's participation constitutes a threat to public safety. Thankfully, there are robust eligibility criteria to help judicial and health care professionals make those determinations. This guidance can help ensure "equitable access, services, and outcomes for all sociodemographic and sociocultural groups," including "guidance for treatment courts to monitor and rectify unwarranted cultural disparities."[33] The eligibility guidance, moreover, can help diversion programs remove inappropriate restrictions and exclusions, ensure evidence-based care, connect individuals to complementary services, as well as avoid conflicts of interest. And just as important, the Board of Trustees agrees that:

> All persons meeting evidence-based eligibility criteria for treatment court receive the same opportunity to participate and succeed in the program regardless of their sociodemographic characteristics or sociocultural identity, including but not limited to their race, ethnicity, sex, gender identity, sexual orientation, age, socioeconomic status, national origin, native language, religion, cultural practices, and physical, medical, or other conditions.[34]

AMA POLICY

A bedrock of AMA advocacy is found in Policy H-430-987, "Medications for Opioid Use Disorder in Correctional Facilities," which provides, "Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated." This policy also calls for the AMA to advocate for

> . . . legislation, standards, policies, and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.

The Board of Trustees recommends that diversion programs be held to the same standards.

The AMA also supports "veterans courts" as "a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder." (Policy H-510-979, "Support for Veterans Courts"). If AMA policy supports broad access to veterans' courts as a matter of policy, the Board of Trustees does not see any reason why such policy should not also apply to other types of diversion programs. Similarly, AMA policy calling to support "justice reinvestment initiatives … and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs," does not distinguish between nonviolent and violent offenses. (Policy H-94-931, "AMA Support for Justice Reinvestment Initiatives").

Finally, AMA Ethics Policy recognizes that, "Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law." (Policy E-9.7.2, "Court-Initiated Medical Treatment in Criminal Cases"). This policy also counsels for physicians to, "Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered." (Policy E-9.7.2, "Court-Initiated Medical Treatment in Criminal Cases"). Thus, while the justice system may have guidance about which individuals are eligible for a diversion program, the physician's role is not to raise barriers to such care.

RECOMMENDATIONS

The Board of Trustees recommends that existing policy – Policy H-100.955, entitled, "Support for Drug Courts" – be amended by addition and deletion in lieu of Resolution 202 as follows:

> Support for Diversion Programs, Including Drug Courts, Mental Health Courts, Veterans Courts, Sobriety Courts, and Similar Programs
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> Our AMA:
>
> (1) supports the establishment and use of diversion and treatment programs ~~drug courts~~, including drug courts, mental health courts, veterans courts, sobriety courts, and other types of similar programs, as an effective method of intervention within a comprehensive system of community-based supports and services for individuals with a mental illness or substance use disorder involved in the justice system ~~addictive disease who are convicted of nonviolent crimes~~;
> (2) encourages legislators and court systems to establish diversion and treatment programs ~~drug courts~~ at the state and local level in the United States; ~~and~~
> (3) encourages diversion and treatment programs ~~drug courts~~ to rely upon evidence-based models of care, including medications for opioid use disorder, for those who the judge or court determine would benefit from intervention, including treatment, rather than incarceration; and
> (4) supports individuals enrolled in diversion or treatment programs not be removed from a program solely because of evidence showing that an individual used illegal drugs while enrolled. (Modify HOD Policy)

Fiscal Note: Less than $500.

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